

MONTANA LEGISLATIVE HISTORY

Chapter 173 19 99

Bill H 136 S _____ Original bill & history ✓C

H. Committee on Bus. Regs. + Labor

S. Committee on P.S. Health, Wel. + Safety

Hearing Date(s) 4/19 ✓C

Hearing Date(s) 3/12 ✓C

7/22 _____C

_____C

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_____C

_____C

Date Out _____C

Did this bill originate in an interim committee? _____Yes ✓No

Committee _____

Report _____

LEGISLATIVE HISTORIES

The 1997 Montana Legislature dramatically changed the nature of legislative minutes. This altered format continues with the 1999 legislative minutes. The minutes from House committees are extremely sparse in content, offering no substantive information from which to glean legislative intent. The Senate committees' minutes are fuller in content.

Exhibits, which include written statements, attendant information, roll call votes, roll call attendance, a list of those from the public who were present, and specific action taken on legislative bills, will be available only through the Historical Society Archives, 444-4774, and from a CD-ROM produced by the Legislative Services Division, 444-3064.

Just as in the 1997 legislative session, the 1999 House and Senate committee hearings were recorded. For information on accessing the tapes, or purchasing them, contact the Archives, 444-4774.

If you have concerns over the format of these legislative minutes, it is suggested that you contact your state legislators.

- PERCENTAGE OF ORGANIC PRODUCERS, PROCESSORS, AND HANDLERS; REQUIRING THAT THE PROGRAM BE ADMINISTERED BY THE DEPARTMENT OF AGRICULTURE ACCORDING TO RULES ADOPTED BY THE DEPARTMENT WITH ADVICE FROM AN ORGANIC COMMODITY ADVISORY COUNCIL; ESTABLISHING AN ACCOUNT; AMENDING SECTIONS 50-31-103 AND 50-31-203, MCA; REPEALING SECTIONS 50-31-221, 50-31-222, 50-31-223, AND 50-31-231; AND PROVIDING EFFECTIVE DATES 576
- 173 (*House Bill No. 136; Williams*) DECREASING THE LOOKBACK PERIOD FOR PREEXISTING CONDITION EXCLUSIONS; PROVIDING FOR INFLATIONARY ADJUSTMENTS FOR CERTAIN SPECIFIED BENEFITS; GRANTING EXPLICIT AUTHORITY TO BORROW MONEY TO THE COMPREHENSIVE HEALTH ASSOCIATION; SUBSTITUTING ANNUAL ASSESSMENTS FOR FISCAL YEAREND ASSESSMENTS; PROVIDING VOTING AUTHORITY FOR THE PUBLIC INTEREST MEMBER OF THE COMPREHENSIVE HEALTH ASSOCIATION BOARD; ALLOWING THE COMMISSIONER OF INSURANCE TO REMOVE BOARD MEMBERS OF THE COMPREHENSIVE HEALTH ASSOCIATION BOARD THAT DO NOT ACTIVELY PARTICIPATE IN THE AFFAIRS OF THE BOARD; PROVIDING A NOTIFICATION REQUIREMENT FOR HEALTH MAINTENANCE ORGANIZATIONS; REQUIRING THE COMMISSIONER OF INSURANCE TO INCLUDE THE PREMIUM VOLUME OF AFFILIATES WHEN DETERMINING BOARD MEMBERSHIP FOR THE COMPREHENSIVE HEALTH ASSOCIATION; AMENDING SECTIONS 33-22-1501, 33-22-1503, 33-22-1504, 33-22-1513, 33-22-1515, 33-22-1516, AND 33-22-1521, MCA; AND PROVIDING AN EFFECTIVE DATE 585
- 174 (*House Bill No. 154; Gallus*) CLARIFYING THE PROHIBITION AGAINST OFFERING ANY FORM OF INCENTIVE OR REBATE TO PAY ALL OR PART OF A CASUALTY OR PROPERTY INSURANCE DEDUCTIBLE RELATED TO THE SALE, REPAIR, OR REPLACEMENT OF AUTOMOBILE GLASS; MAKING THE PROHIBITION APPLICABLE TO AUTOMOBILE REPAIR BUSINESSES; DEFINING A VIOLATION OF THE PROHIBITION AS AN UNFAIR TRADE PRACTICE AND RENDERING THE VIOLATOR SUBJECT TO INSURANCE FRAUD STATUTES; AND AMENDING SECTION 30-14-225, MCA 593
- 175 (*House Bill No. 173; Somerville*) ADOPTING THE EMERGENCY MANAGEMENT ASSISTANCE COMPACT AS AN INTERSTATE COMPACT; PROVIDING THE TERMS OF THE COMPACT; AUTHORIZING REQUESTS FOR AND RESPONSES TO REQUESTS FROM OTHER STATES FOR THE PURPOSE OF INTERSTATE SHARING OF EQUIPMENT AND PERSONNEL TO RESPOND TO NATURAL AND HUMAN-CAUSED DISASTERS AND EMERGENCIES; APPOINTING THE ADMINISTRATOR OF THE DISASTER AND EMERGENCY SERVICES DIVISION OF THE DEPARTMENT OF MILITARY AFFAIRS AS THE ADMINISTRATOR OF THE COMPACT; PROVIDING FOR SUPPLEMENTARY AGREEMENTS TO IMPLEMENT THE COMPACT; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE 594
- 176 (*House Bill No. 474; Hibbard*) ALLOWING THE PUBLIC EMPLOYER REPRESENTATIVE TO PETITION BOARD OF PERSONNEL APPEALS TO REDETERMINE THE APPROPRIATE UNIT FOR COLLECTIVE BARGAINING IN THE EVENT THAT A STATE AGENCY OR FACILITY OF A STATE AGENCY UNDERGOES SIGNIFICANT REORGANIZATION; PROHIBITING THE BOARD

HISTORY AND FINAL STATUS 1999

2/05	Rereferred to Appropriations		
2/16	Hearing		
3/11	Committee Executive Action--Bill Passed as Amended	14	4
3/13	Committee Report--Bill Passed as Amended		
3/22	2nd Reading Passed as Amended	84	16
3/24	3rd Reading Passed	80	18
	Transmitted to Senate		
3/24	Referred to Finance and Claims		
4/08	Hearing		
4/09	Committee Executive Action--Bill Concurred	18	0
4/09	Committee Report--Bill Concurred		
4/10	2nd Reading Concurred	50	0
4/12	3rd Reading Concurred	50	0
	Returned to House		
4/13	Sent to Enrolling		
4/14	Returned from Enrolling		
4/14	Signed by Speaker		
4/15	Signed by President		
4/16	Transmitted to Governor		
4/21	Signed by Governor		
4/22	Chapter Number Assigned		
	Chapter Number 392		
	Effective Date: 7/01/1999 - All Sections		

HB 136 Introduced by C. Williams

LC0428 Drafter: B. Campbell

Decrease the Lookback Period for Preexisting Condition Exclusions;...

By Request of State Auditor

12/22	Introduced		
1/04	1st Reading		
1/04	Referred to Business and Labor		
1/19	Hearing		
1/22	Committee Executive Action--Bill Passed as Amended	17	1
1/23	Committee Report--Bill Passed as Amended		
1/26	2nd Reading Passed	89	11
1/27	3rd Reading Passed	86	13
	Transmitted to Senate		
1/28	Referred to Public Health, Welfare and Safety		
3/12	Hearing		
3/13	Committee Executive Action--Bill Concurred	8	0
3/13	Committee Report--Bill Concurred		
3/16	2nd Reading Concurred	48	1
3/17	3rd Reading Concurred	46	3
	Returned to House		
3/18	Sent to Enrolling		
3/19	Returned from Enrolling		
3/20	Signed by Speaker		
3/23	Signed by President		
3/23	Transmitted to Governor		
3/25	Signed by Governor		

3/27 Chapter Number Assigned
 Chapter Number 173
 Effective Date: 7/01/1999 - All Sections

HB 137 Introduced by Anderson *LC0128 Drafter: Heiman*

Establish New Procedures for Resolving Disputes Between the Department of Revenue and Persons or Other Entities;...

By Request of Department of Revenue

12/22	Introduced		
1/04	1st Reading		
1/04	Referred to Taxation		
1/04	Fiscal Note Requested		
1/07	Fiscal Note Received		
1/08	Fiscal Note Signed		
1/08	Fiscal Note Printed		
1/11	Hearing		
1/25	Committee Executive Action--Bill Passed as Amended	18	2
1/26	Committee Report--Bill Passed as Amended		
1/30	2nd Reading Passed	93	5
2/01	3rd Reading Passed	95	3
	Transmitted to Senate		
2/02	Referred to Taxation		
2/09	Hearing		
2/09	Committee Executive Action--Bill Concurred	6	0
2/09	Committee Report--Bill Concurred		
2/15	2nd Reading Concurred	50	0
2/16	3rd Reading Concurred	49	0
	Returned to House		
2/16	Sent to Enrolling		
2/17	Returned from Enrolling		
2/17	Signed by Speaker		
2/18	Signed by President		
2/19	Transmitted to Governor		
2/24	Signed by Governor		
3/02	Chapter Number Assigned		
	Chapter Number 36		
	Effective Date: 2/24/1999 - All Sections		

HB 138 Introduced by Harper *LC0142 Drafter: Kurtz*

Eliminate the Annual License Renewal Fee for Wholesale Gasoline and Special Fuel Distributors;...

By Request of Department of Transportation

12/22	Introduced
1/04	1st Reading
1/04	Referred to Taxation
1/04	Fiscal Note Requested
1/08	Fiscal Note Received
1/10	Revised Fiscal Note Requested
1/10	Revised Fiscal Note Received
1/11	Fiscal Note Signed

HOUSE BILL NO. 136

INTRODUCED BY WILLIAMS C

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT INCLUDING HEALTH MAINTENANCE ORGANIZATIONS AS MEMBERS OF THE MONTANA COMPREHENSIVE HEALTH ASSOCIATION; DECREASING THE LOOKBACK PERIOD FOR PREEXISTING CONDITION EXCLUSIONS; PROVIDING FOR INFLATIONARY ADJUSTMENTS FOR CERTAIN SPECIFIED BENEFITS; GRANTING EXPLICIT AUTHORITY TO BORROW MONEY TO THE COMPREHENSIVE HEALTH ASSOCIATION; SUBSTITUTING ANNUAL ASSESSMENTS FOR FISCAL YEAREND ASSESSMENTS; PROVIDING VOTING AUTHORITY FOR THE PUBLIC INTEREST MEMBER OF THE COMPREHENSIVE HEALTH ASSOCIATION BOARD; ALLOWING THE COMMISSIONER OF INSURANCE TO REMOVE BOARD MEMBERS OF THE COMPREHENSIVE HEALTH ASSOCIATION BOARD THAT DO NOT ACTIVELY PARTICIPATE IN THE AFFAIRS OF THE BOARD; REQUIRING THE COMMISSIONER OF INSURANCE TO INCLUDE THE PREMIUM VOLUME OF AFFILIATES WHEN DETERMINING BOARD MEMBERSHIP FOR THE COMPREHENSIVE HEALTH ASSOCIATION; AND AMENDING SECTIONS 33-22-1501, 33-22-1503, 33-22-1504, 33-22-1513, 33-22-1515, 33-22-1516, AND 33-22-1521, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-22-1501, MCA, is amended to read:

"33-22-1501. Definitions. As used in this part, the following definitions apply:

- (1) "Association" means the comprehensive health association created by 33-22-1503.
- (2) "Association plan" means a policy of insurance coverage that is offered by the association and that is certified by the association as required by 33-22-1521.
- (3) "Association plan premium" means the charge determined pursuant to 33-22-1512 for membership in the association plan based on the benefits provided in 33-22-1521.
- (4) "Association portability plan" means a policy of insurance coverage that is offered by the association to a federally defined eligible individual.
- (5) "Association portability plan premium" means the charge determined by the association and approved by the commissioner for an association portability plan.

(6) "Block of business" means a separate risk pool grouping of covered individuals, enrollees, dependents as defined by rules of the commissioner.

(7) "Eligible person" means an individual who:

(a) is a resident of this state and applies for coverage under the association plan;

(b) unless the individual's eligibility is waived by the association, has, within 6 months prior to the date of application, been rejected for disability insurance or health service benefits by at least two insurers, societies, or health service corporations or has had a restrictive rider or preexisting condition limitation, which limitation is required by at least two insurers, societies, or health service corporation ~~which~~ that has the effect of substantially reducing coverage from that received by a person considered a standard risk; and

(c) is not eligible for any other form of disability insurance or health service benefits.

(8) "Federally defined eligible individual" means a person who is an individual enrolling in the association portability plan:

(a) for whom, as of the date on which the individual seeks coverage under the association portability plan, the aggregate of the periods of creditable coverage is 18 months or more and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan;

(b) who does not have other health insurance coverage;

(c) who is not eligible for coverage under:

(i) a group health plan;

(ii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4; or

(iii) a state plan under Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, or a successor program;

(d) for whom the most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud;

(e) who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected that coverage; and

(f) who has exhausted continuation coverage under the COBRA continuation provision or program described in subsection (8)(e) if the individual elected the continuation coverage described in subsection (8)(e).

1 (9) "Health service corporation" means a corporation operating pursuant to Title 33, chapter 30,
2 and offering or selling contracts of disability insurance.

3 (10) "Insurance arrangement" means any plan, program, contract, or other arrangement to the
4 extent not exempt from inclusion by virtue of the provisions of the federal Employee Retirement Income
5 Security Act of 1974 under which one or more employers, unions, or other organizations provide to their
6 employees or members, either directly or indirectly through a trust of a third-party administrator, health
7 care services or benefits other than through an insurer.

8 (11) "Insurer" means a company operating pursuant to Title 33, chapter 2 or 3, and offering or
9 selling policies or contracts of disability insurance, as provided in Title 33, chapter 22.

10 (12) "Lead carrier" means the licensed administrator or insurer selected by the association to
11 administer the association plan.

12 (13) "Medicare" means coverage under both parts A and B of Title XVIII of the Social Security
13 Act, 42 U.S.C. 1395, et seq., as amended.

14 (14) "Preexisting condition" means any condition for which an applicant for coverage under the
15 association plan has received medical attention during the 5 3 years immediately preceding the filing of
16 an application.

17 (15) "Society" means a fraternal benefit society operating pursuant to Title 33, chapter 7, and
18 offering or selling certificates of disability insurance."
19

20 Section 2. Section 33-22-1503, MCA, is amended to read:

21 "33-22-1503. Comprehensive health association -- mandatory membership. (1) There is
22 established a nonprofit legal entity, to be known as the Montana comprehensive health association, with
23 participating membership consisting of all insurers, insurance arrangements, societies, health maintenance
24 organizations, and health service corporations licensed or authorized to do business in this state. The
25 association is exempt from taxation under the laws of this state, and all property owned by the
26 association is exempt from taxation.

27 (2) All participating members shall maintain their membership in the association as a condition
28 for writing health care benefits policies or contracts in this state. The association shall submit its articles,
29 bylaws, and operating rules to the commissioner for approval.

30 (3) The association may:

(a) exercise the powers granted to insurers under the laws of this state;

(b) sue or be sued;

(c) borrow money;

~~(e)~~(d) enter into contracts with insurers, administrators, similar associations in other states, other persons for the performance of administrative functions;

~~(e)~~(e) establish administrative and accounting procedures for the operation of the association

~~(e)~~(f) provide for the reinsuring of risks incurred as a result of issuing the coverages required by members of the association;

~~(f)~~(g) provide for the administration by the association of policies that are reinsured pursuant to subsection (3)~~(e)~~(f); and

~~(g)~~(h) issue additional types of health insurance policies to provide optional coverage, including medicare supplemental health insurance."

Section 3. Section 33-22-1504, MCA, is amended to read:

"33-22-1504. Association board of directors -- organization. (1) There is a board of directors of the association, consisting of eight individuals:

(a) one from each of the five participating members of the association with the highest annual premium volume of disability insurance contracts, health maintenance organization health care service agreements, or health service corporation contracts, derived from or on behalf of residents in the previous calendar year, as determined by the commissioner;

(b) two members at large who must be participating members of the association, appointed by the commissioner; and

(c) a member at large, appointed by the commissioner to represent the public interest, ~~who shall serve in an advisory capacity only.~~

(2) The public interest board member is entitled to one board vote. Each of the seven board members representing the association members is entitled to a weighted average vote, in person or by proxy, based on the association member's annual Montana premium volume. However, a board member may not have more than 50% of the vote.

(3) Members of the board may be reimbursed from the money of the association for expenses incurred by them because of their service as board members but may not otherwise be compensated by

1 the association for their services. The costs of conducting the meetings of the association and its board
2 of directors must be borne by participating members of the association in accordance with 33-22-1513.

3 (4) The commissioner may replace a board member if the commissioner determines that the board
4 member is not actively participating in the affairs of the board or if the participating member does not
5 appoint a board representative within a reasonable time period. A board member appointed under
6 subsection (1)(a) must be replaced by a participating member of the association with the next highest
7 annual Montana premium volume of disability insurance contracts, health maintenance organization health
8 care service agreements, or health service corporation contracts, derived from or on behalf of residents
9 in the previous calendar year, as determined by the commissioner.

10 (5) The commissioner shall include the applicable premium volume of all affiliates, as defined in
11 33-2-1101, in making the determination required by subsection (1)(a) or (4)."

12
13 **Section 4. Section 33-22-1513, MCA, is amended to read:**

14 **"33-22-1513. Operation of association plan and association portability plans. (1) Upon acceptance**
15 **by the lead carrier under 33-22-1516, an eligible person may enroll in the association plan by payment**
16 **of the association plan premium to the lead carrier.**

17 (2) Upon application by a federally defined eligible individual to the lead carrier for an association
18 portability plan, the association may not:

19 (a) decline to offer an association portability plan; or

20 (b) impose a preexisting condition exclusion with respect to an individual's association portability
21 plan coverage if application for association portability plan coverage is made within 63 days following
22 termination of the applicant's most recent prior creditable coverage.

23 (3) Not less than 88% of the association plan premiums paid to the lead carrier may be used to
24 pay claims and not more than 12% may be used for payment of the lead carrier's direct and indirect
25 expenses as specified in 33-22-1514.

26 (4) Any income in excess of the costs incurred by the association in providing reinsurance or
27 administrative services must be held at interest and used by the association to offset past and future
28 losses due to claims expenses of the association plan and the association portability plan or be allocated
29 to reduce association plan premiums.

30 (5) (a) Each participating member of the association shall share the losses due to claims expenses

1 of the association plan and the association portability plan for plans issued or approved for issuance
2 the association and shall share in the operating and administrative expenses incurred or estimated to
3 incurred by the association incident to the conduct of its affairs. Claims expenses of the association
4 and the association portability plan that exceed the premium payments allocated to the payment of
5 benefits are the liability of the association members. Association members shall share in the claims
6 expenses of the association plan and the association portability plan and operating and administrative
7 expenses of the association in an amount equal to the ratio of the association member's total disability
8 insurance premium received from or on behalf of Montana residents divided by the total disability
9 insurance premium received by all association members from or on behalf of Montana residents
10 determined by the commissioner.

11 (b) For purposes of this subsection (5), "total disability insurance premium" does not include
12 premiums received from disability income insurance, credit disability insurance, disability waiver insurance
13 or life insurance.

14 (6) The association shall make an annual determination of each association member's liability
15 if any, and may make an annual ~~fiscal year-end~~ assessment if necessary. Assessments related to the
16 operation and expenses of the association plan must be determined and levied separately from
17 assessments related to the operation and expenses of the association portability plan. The association
18 may also, subject to the approval of the commissioner, provide for interim assessments against the
19 association members as may be necessary to ensure the financial capability of the association in meeting
20 the incurred or estimated claims expenses of the association plan and the association portability plan and
21 operating and administrative expenses of the association until the association's next annual ~~fiscal year-end~~
22 assessment. Payment of an assessment is due within 30 days of receipt by an association member of a
23 written notice of a ~~fiscal year-end~~ annual or interim assessment. Failure by a contributing member to
24 tender to the association the assessment within 30 days is grounds for termination of membership. An
25 association member that ceases to do disability insurance business within the state remains liable for
26 assessments through the calendar year during which disability insurance business ceased. The association
27 may decline to levy an assessment against an association member if the assessment, as determined
28 pursuant to this section, would not exceed \$10.

29 (7) Any annual ~~fiscal year-end~~ or interim assessment relating to the operation and expenses of the
30 association plan levied against an association member may be offset, in an amount equal to the

1 assessment paid to the association, against the premium tax payable by that association member pursuant
2 to 33-2-705 for the year in which the annual ~~fiscal year-end~~ or interim assessment is levied. The insurance
3 commissioner shall report to the office of budget and program planning, as a part of the information
4 required by 17-7-111, the total amount of premium tax offset claimed by association members during the
5 preceding biennium. Assessments relating to the operation and expenses of the association portability plan
6 and levied against an association member may not be offset against the premium tax payable by that
7 association member."

8

9 Section 5. Section 33-22-1515, MCA, is amended to read:

10 "33-22-1515. Solicitation of eligible persons. (1) The association, pursuant to a plan approved
11 by the commissioner, shall disseminate appropriate information to the residents of this state regarding the
12 existence of the association plan and the means of enrollment. Means of communication may include use
13 of the press, radio, and television, as well as publication in appropriate state offices and publications.

14 (2) The association shall devise and implement means of maintaining public awareness of this part
15 and shall administer this part in a manner that facilitates public participation in the association plan.

16 (3) All licensed disability insurance producers may engage in the selling or marketing of the
17 association plan. The lead carrier shall pay an insurance producer's referral fee of at least \$25 to each
18 licensed disability insurance producer who refers an applicant to the association plan, if the applicant is
19 accepted. The amount of the referral fee must be set by the board of directors of the association and is
20 subject to the approval of the commissioner. The referral fees must be paid by the lead carrier from
21 money received as premiums for the association plan.

22 (4) An insurer, society, health maintenance organization, or health service corporation that rejects
23 or applies underwriting restrictions to an applicant for disability insurance shall notify the applicant of the
24 existence of the association plan, requirements for being accepted in it the association plan, and the
25 procedure for applying to it the association plan."

26

27 Section 6. Section 33-22-1516, MCA, is amended to read:

28 "33-22-1516. Enrollment by eligible person. (1) The association plan must be open for enrollment
29 by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to
30 the lead carrier. The certificate must provide:

- 1 (a) the name, address, and age of the applicant and length of the applicant's residence in the
2 state;
3 (b) the name, address, and age of spouse and children, if any, if they are to be insured;
4 (c) written evidence that the person fulfills all of the elements of an eligible person, as defined
5 in 33-22-1501; and
6 (d) a designation of coverage desired.

7 (2) Within 30 days of receipt of the certificate, the lead carrier shall either reject the application
8 for failing to comply with the requirements of subsection (1) or forward the eligible person a notice of
9 acceptance and billing information. Insurance is effective on the first of the month following acceptance.

10 (3) An eligible person may not purchase more than one policy from the association plan.

11 (4) A person who obtains coverage under the association plan may not be covered for any
12 preexisting condition during the first 12 months of coverage under the association plan if the person was
13 diagnosed or treated for that condition during the 5 3 years immediately preceding the filing of an
14 application. The association may not apply a preexisting condition exclusion to coverage under the
15 association portability plan if application for association portability plan coverage is made within 63 days
16 following termination of the applicant's most recent prior creditable coverage. The association shall waive
17 any time period applicable to a preexisting condition exclusion for the period of time that any other eligible
18 individual was covered under the following types of coverage if the coverage was continuous to a date
19 not more than 30 days prior to submission of an application for coverage under the association plan:

20 (a) an individual health insurance policy that includes coverage by an insurance company, a
21 fraternal benefit society, a health service corporation, or a health maintenance organization that provides
22 benefits similar to or exceeding the benefits provided by the association plan; or

23 (b) an employer-based health insurance benefit arrangement that provides benefits similar to or
24 exceeding the benefits provided by the association plan."

25
26 Section 7. Section 33-22-1521, MCA, is amended to read:

27 "33-22-1521. Association plan -- minimum benefits. A plan of health coverage must be certified
28 as an association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting part
29 7), and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or
30 exceeds the following minimum standards:

(1) (a) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least 50% of the covered expenses required by this section in excess of an annual deductible that does not exceed \$1,000 per person. The coverage must include a limitation of \$5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but the maximums may not be less than \$100,000.

(b) One association plan must be offered with coverage for 80% of the covered expenses provided in this section in excess of an annual deductible that does not exceed \$1,000 per person. This association plan must provide a maximum lifetime benefit of at least \$500,000.

(c) Covered expenses for plans under subsection (1)(a) and (1)(b) must be paid as specified in provider contracts or, in the absence of a provider contract, at the prevailing charge in the state where the service is provided.

(d) The board may authorize other association plans, including managed care plans as defined in 33-36-103.

(2) Covered expenses for plans offered under subsections (1)(a) and (1)(b) must be the usual and customary charges for the following medically necessary services and articles when prescribed by a physician or other licensed health care professional and when designated in the contract:

- (a) hospital services;
- (b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;
- (c) use of radium or other radioactive materials;
- (d) oxygen;
- (e) anesthetics;
- (f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3);
- (g) services of a physical therapist;
- (h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;
- (i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;
- (j) rental or purchase of durable medical equipment, which must be reimbursed after the deductible has been met at the rate of 50%, up to a maximum of \$1,000;

- (k) prosthetics, other than dental;
- (l) services of a licensed home health agency, up to a maximum of 180 visits per year;
- (m) drugs requiring a physician's prescription that are approved for use in human beings in the manner prescribed by the United States food and drug administration, covered at 50% of the expense up to an annual maximum of \$1,000;
- (n) medically necessary, nonexperimental transplants of the kidney, pancreas, heart, heart/lungs, liver, cornea, and high-dose chemotherapy bone marrow transplantation, limited to a lifetime maximum of \$150,000, with an additional benefit not to exceed \$10,000 for expenses associated with the donor;
- (o) pregnancy, including complications of pregnancy;
- (p) newborn infant coverage, as required by 33-22-301;
- (q) sterilization;
- (r) immunizations;
- (s) outpatient rehabilitation therapy;
- (t) foot care for diabetics;
- (u) services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60 days per year; and
- (v) travel, other than transportation by a licensed ambulance service, to the nearest facility qualified to treat the patient's medical condition when approved in advance by the insurer.
- (3) (a) Covered expenses for the services or articles specified in this section do not include:
- (i) home and office calls, except as specifically provided in subsection (2);
- (ii) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);
- (iii) the first \$20 of diagnostic x-ray and laboratory charges in each 14-day period;
- (iv) oral surgery, except as specifically provided in subsection (2);
- (v) that part of a charge for services or articles that exceeds the prevailing charge in the locality state where the service is provided; or
- (vi) care that is primarily for custodial or domiciliary purposes that would not qualify as eligible services under medicare.
- (b) Covered expenses for the services or articles specified in this section do not include charges

for:

(i) care or for any injury or disease arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance or medicare;

(ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or congenital bodily defect to restore normal bodily functions;

(iii) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition, except as provided by subsection (2);

(iv) confinement in a private room to the extent that it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

(vi) room and board for a nonemergency admission on Friday or Saturday;

(vii) routine well baby care;

(viii) complications to a newborn, unless no other source of coverage is available;

(ix) reversal of sterilization;

(x) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

(xi) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

(xii) artificial insemination or treatment for infertility; or

(xiii) breast augmentation or reduction."

- END -

MINUTES

MONTANA HOUSE OF REPRESENTATIVES 56th LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS AND LABOR

Call to Order: By CHAIRMAN BRUCE SIMON, on January 19, 1999 at
8:00 A.M., in Room 104 Capitol.

ROLL CALL

Members Present:

Rep. Bruce Simon, Chairman (R)
Rep. Bob Pavlovich, Vice Chairman (D)
Rep. Paul Sliter, Vice Chairman (R)
Rep. Joe Barnett (R)
Rep. Rod Bitney (R)
Rep. Sylvia Bookout-Reinicke (R)
Rep. Roy Brown (R)
Rep. David Ewer (D)
Rep. Carol C. Juneau (D)
Rep. Billie Krenzler (D)
Rep. Bob Lawson (R)
Rep. Gay Ann Masolo (R)
Rep. Gary Matthews (D)
Rep. Joe McKenney (R)
Rep. Carolyn Squires (D)
Rep. Jay Stovall (R)
Rep. Cliff Trexler (R)
Rep. Carley Tuss (D)

Members Excused: None.

Members Absent: None.

Staff Present: Stephen Maly, Legislative Branch
Pati O'Reilly, Committee Secretary

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing(s) & Date(s) Posted: HB 167, HB 150, HB 155, HB 136
POSTED 1/7/1999 AND HB 250
POSTED 1/14/1999
Executive Action: HB 167, 200, 229, 250, 43, 227

Rep. Bookout questions Rep. Ewer

{Tape : 1; Side : B; Approx. Time Counter : 0 - 49}

Rep. Simon questions Secretary Cooney.

{Tape : 1; Side : B; Approx. Time Counter : 49 - 78}

Closing by Sponsor: Rep. Menahan closed on HB 150.

{Tape : 1; Side : B; Approx. Time Counter : 78 - 87}

HEARING ON HB 136

Sponsor: Rep. Williams, HD 69 introduced HB 136. EXHIBIT(2)
EXHIBIT(3) EXHIBIT(4)

{Tape : 1; Side : B; Approx. Time Counter : 87 - 182}

Proponents: Bill Jensen. Lawyer with Blue Cross-Blue Shield and a board member and Chairman of the Montana Comprehensive Health Assn.

{Tape : 1; Side : B; Approx. Time Counter : 182 - 238}

Claudia Clifford, Montana Dept. of Insurance, State Auditors office.

{Tape : 1; Side : B; Approx. Time Counter : 238 - 279}

Don Allen, Montana Medical Benefits Plan.

{Tape : 1; Side : B; Approx. Time Counter : 279 - 285}

Opponents: None

Questions from Committee Members and Responses:

Reps. Lawson, Krenzler and Bookout question Jensen.

{Tape : 1; Side : B; Approx. Time Counter : 285 - 392}

Rep. Simon questions C. Clifford.

{Tape : 1; Side : B; Approx. Time Counter : 392 - 459}

Closing by Sponsor: Rep. Williams closed on HB 136

{Tape : 1; Side : B; Approx. Time Counter : 459 - 500}

EXECUTIVE ACTION ON HB 250

Motion: Rep. Krenzler moved that HB 250 DO PASS.

{Tape : 2; Side : A; Approx. Time Counter : 0 - 6}

Motion/Vote: Rep. Pavlovich moved that HB 250 BE AMENDED.

Motion carried 18-0.

{Tape : 2; Side : A; Approx. Time Counter : 6 - 14}

MINUTES

**MONTANA HOUSE OF REPRESENTATIVES
56th LEGISLATURE - REGULAR SESSION**

COMMITTEE ON BUSINESS AND LABOR

Call to Order: By **CHAIRMAN BRUCE SIMON**, on January 22, 1999 at 8:00 A.M., in Room 104 Capitol.

ROLL CALL

Members Present:

Rep. Bruce Simon, Chairman (R)
Rep. Bob Pavlovich, Vice Chairman (D)
Rep. Paul Sliter, Vice Chairman (R)
Rep. Joe Barnett (R)
Rep. Rod Bitney (R)
Rep. Sylvia Bookout-Reinicke (R)
Rep. Roy Brown (R)
Rep. David Ewer (D)
Rep. Carol C. Juneau (D)
Rep. Billie Krenzler (D)
Rep. Bob Lawson (R)
Rep. Gay Ann Masolo (R)
Rep. Gary Matthews (D)
Rep. Joe McKenney (R)
Rep. Carolyn Squires (D)
Rep. Jay Stovall (R)
Rep. Cliff Trexler (R)
Rep. Carley Tuss (D)

Members Excused: None.

Members Absent: None.

Staff Present: Stephen Maly, Legislative Branch
Pati O'Reilly, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing(s) & Date(s) Posted: SB 51, SB 51, HB 277, HB 265,
HB 264,, 1/14/1999

Executive Action: HB 265, HB 98, HB 150, HB
136, HB 121, HB 186, HB 216,
HB 249, SB 26, SB 51, HB 277,
HB 264, HB 155, HB 31

EXECUTIVE ACTION ON HB 136

Motion: REP. SQUIRES moved that HB 136 DO PASS.
{Tape : 2; Side : A; Approx. Time Counter : 425 - 440}

Motion/Vote: REP. SQUIRES moved that HB 136 BE AMENDED. Motion carried 16-2 with Masolo and Tuss voting no.
{Tape : 2; Side : A; Approx. Time Counter : 440 - 500}

Motion/Vote: REP. SQUIRES moved that HB 136 DO PASS AS AMENDED. Motion carried 17-1 with Tuss voting no.
{Tape : 2; Side : B; Approx. Time Counter : 0 - 8}

EXECUTIVE ACTION ON HB 186

Motion/Vote: REP. MASOLO moved that HB 186 DO PASS. Motion carried unanimously.
{Tape : 2; Side : B; Approx. Time Counter : 8 - 35}

EXECUTIVE ACTION ON HB 216

Motion: REP. PAVLOVICH moved that HB 216 DO PASS.
{Tape : 2; Side : B; Approx. Time Counter : 35 - 51}

Motion: REP. PAVLOVICH moved that HB 216 BE AMENDED.
{Tape : 2; Side : B; Approx. Time Counter : 51 - 53}

Substitute Motion/Vote: REP. SLITER made a substitute motion that HB 216 BE AMENDED. Substitute motion carried unanimously.
{Tape : 2; Side : B; Approx. Time Counter : 53 - 58}

Motion/Vote: REP. SLITER moved that HB 216 DO PASS AS AMENDED. Motion carried 12-6 with Barnett, Bookout-Reinicke, Brown, Ewer, Lawson, and Simon voting no.
{Tape : 2; Side : B; Approx. Time Counter : 58 - 66}]

EXECUTIVE ACTION ON HB 249

Motion/Vote: REP. PAVLOVICH moved that HB 249 DO PASS AS AMENDED. Motion failed 8-10 with Bookout-Reinicke, Ewer, Juneau, Krenzler, Matthews, Pavlovich, Squires, and Tuss voting aye.
{Tape : 2; Side : B; Approx. Time Counter : 76 - 106}

MINUTES

MONTANA SENATE 56th LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE AND SAFETY

Call to Order: By **CHAIRMAN AL BISHOP**, on March 12, 1999 at 3:15 A.M., in Room 410 Capitol. **VICE CHAIRMAN FRED THOMAS** was **ACTING CHAIRMAN**.

ROLL CALL

Members Present:

Sen. Al Bishop, Chairman (R)
Sen. Fred Thomas, Vice Chairman (R)
Sen. Sue Bartlett (D)
Sen. John C. Bohlinger (R)
Sen. Bob DePratu (R)
Sen. Dorothy Eck (D)
Sen. Eve Franklin (D)
Sen. Duane Grimes (R)
Sen. Don Hargrove (R)

Members Excused: Sen. Dale Berry (R)
Sen. Chris Christiaens (D)

Members Absent: None.

Staff Present: Susan Fox, Legislative Branch
Martha McGee, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing(s) & Date(s) Posted: HB 136, HB 269, 3/9/1999
Executive Action: HB 126; HB 275; HB 580; HB
136; HB 269; HB 583; HB 44; HB
551

HEARING ON HB 136

Sponsor: REP. CAROL WILLIAMS, HD 69, Missoula

Proponents: Bill Jensen, General Council for Blue Cross Blue Shield
Claudia Clifford, Insurance Commissioners Officers
Mary Allen, Montana Medical Benefit Plan

Opponents: None

Opening Statement by Sponsor:

REP. CAROL WILLIAMS, HD 69, Missoula opened on her bill. This is an administrative bill for the Montana Comprehensive Health Association. The Association was established in 1985 by the legislature as a non-profit organization for the purpose of supporting and providing insurance for people who were previously uninsurable. This program is a paid for by assessments on all insurers who are licensed to do business in Montana. They have two plans.

EXHIBIT(phs56a01)

One is an association plan, which is a plan to cover high risk customers. These people must have been turned down by two insurers in order to be eligible for this plan. It is quite expensive, but it is something for folks who previously were not able to have any.

The second plan is a portability plan. This is to solve the needs of people who, for example, have been in a group plan previously, used there benefits up, and then have began to work for a small company who cannot provide insurance for them. These people can buy insurance through the portability plan.

There are people in almost every county in Montana who are taking advantage of these programs. There is mention in the bill to authorize the lead carrier, currently Blue Cross Blue Shield in Montana, to lend money for the purposes of cash flow. Also, the bill allows for a public member on the Board to vote on issues.

In addition, there are occasions when there is someone on the board who is not able to do as much work as they thought that they would be able to do. This bill would allow the insurance commissioner to replace any Board member that was not able to fulfill their duties.

The Association is to make their assessments on an annual basis rather than a fiscal year basis. The bill decreases the look-back time from five years to three years. There are other bills that have passed through Committees in order to fund the Association.

{Tape : 1; Side : A; Approx. Time Counter : 0 - 5.2}

Proponents' Testimony:

Bill Jensen, General Council for Blue Cross Blue Shield, rose in support of the bill. One of the things that the Association Board works with are folks that have very poor health and use a significant amount of health care services. One of the things that this would allow, in addition to the other plans, is to allow a managed care plan into the menu of options that are available. At the present time, there are approximately 1264 people on the two plans of the association.

{Tape : 1; Side : A; Approx. Time Counter : 5.2 - 7.1}

Claudia Cliffard, Insurance Commissioners Officers, rose in support of the bill. This bill was put together by the unanimous request of the Board with the provisions included.

{Tape : 1; Side : A; Approx. Time Counter : 7.1 - 7.4}

Mary Allen, Montana Medical Benefit Plan, rose in support of the bill.

{Tape : 1; Side : A; Approx. Time Counter : 7.4 - 8}

Opponents' Testimony: None

Questions from Committee Members and Responses: None

Closing by Sponsor:

REP. WILLIAMS closed on her bill. There is not a fiscal implication for Montana created by this bill. The Montana Comprehensive Health Association is beneficial to many families across the state.

{Tape : 1; Side : A; Approx. Time Counter : 8 - 9.3}

HEARING ON HB 269

Sponsor: REP. BRAD MOLNAR, HD 22, Laurel

Proponents:

Opponents:

Opening Statement by Sponsor:

REP. BRAD MOLNAR, HD 22, Laurel, opened on his bill. All of the amendments on this bill were brought forth by the Department. There are roughly 10,000 charges of child abuse/neglect. Six

changes in the areas they wish to change over the course of the year.

Motion/Vote: SEN. ECK moved that AMENDMENT#HB027501.ads
BE ADOPTED. Motion carried 6-0.
EXHIBIT(phs56a08)

Vote: Motion carried 8-0.
{Tape : 2; Side : A; Approx. Time Counter : 0.5 - 4.7}

EXECUTIVE ACTION ON HB 580

The Committee decided to hold off on this bill until SEN. BARTLETT could talk with the Department of Corrections.
{Tape : 2; Side : A; Approx. Time Counter : 4.7 - 7.3}

EXECUTIVE ACTION ON HB 136

Motion: SEN. ECK moved that HB 136 BE CONCURRED IN.

Discussion: SEN. BOHLINGER said that this bill would provide insurance to those families that need it as a last resort.

Vote: Motion carried 8-0.
{Tape : 2; Side : A; Approx. Time Counter : 7.3 - 9.1}

EXECUTIVE ACTION ON HB 269

Motion: SEN. ECK moved that HB 269 BE CONCURRED IN.

Discussion: SEN. ECK said that one of the things that this bill does that was not mentioned in the hearing is that in discussing this bill with her County Attorney, he felt that this bill is very good. Quite frequently people do not have an attorney until the last stages. Some of these cases would be very hard to defend if they were appealed.

Mr. Hunter commented that there are things in this proposal that may cause some harm to the process. On the other hand, the Department is under the gun so often, and this bill helps deal with that.

Vote: Motion carried 8-0.